Implementing a psycho-educational intervention for care assistants working with people with dementia in aged-care facilities: A qualitative study of facilitators and barriers

Abstract

Psycho-educational interventions hold promise as a means of driving forward benefits for care assistants and care provision as they incorporate both illness-specific education and support for stress-reduction. This qualitative study examines the facilitators and barriers to the implementation of such an intervention for care assistants working with people with dementia in aged-care facilities.

Seven focus-group interviews involving 21 care assistants (female; mean age 43.37±10.0) and individual semi-structured interviews with two managers (female; mean age 45.5 ± 10.26) were conducted two weeks and six months after the intervention, in two aged-care facilities. Interviews were recorded, transcribed and submitted to content analysis by two independent researchers.

Factors facilitating implementation included: intervention format and delivery; provision of emotional support; provision of individual assistance; coordinators' relationship skills; and positive care assistants' attitudes. Barriers included: short-duration of the intervention; resource constraints; limited management support; negative care assistants' attitudes; and residents' level of disability.

Findings enable the interpretation of the experimental results and underscore the importance of collecting the perception of different grades of staff to obtain information relevant to plan effective interventions.

Keywords

Dementia; focus-groups; person-centred care; workforce issues

Introduction

Care assistants occupy a pivotal role in the care of persons with dementia. They are responsible for the majority of daily care to people with dementia in aged-care facilities, being most likely to influence residents' quality of life (1). Yet, despite the demanding nature of their role, they receive little training, are often underappreciated, lack support and experience heavy workloads (1). These conditions are significant sources of care assistants' stress, burnout and job dissatisfaction, which are known to create a disruption in the worker-resident relationship and hinder the delivery of quality care (2, 3). The association between care assistants' wellbeing and provision of person or relationship-centred care has been recognised, with several authors emphasising that if workers are to deliver such a care they need to have their own needs acknowledged and addressed (4, 5). Hence, both person-centred and relationship-centred care place greater emphasis on emotional support, which allows connection, involvement and the promotion of worker wellbeing (4).

Psycho-educational (PE) interventions hold promise as a means of driving forward benefits for care assistants and care provision as they incorporate both illness-specific education and support to foster coping with concrete strategies for problem-solving and stress-reduction. These approaches have been primarily focused on family carers of people with dementia, where they have been associated with positive and consistent effects on several outcome indicators (e.g., burden, depression, anxiety) (6, 7). The commonalities and intersections of formal and informal care (e.g., both can be equally stressful or overwhelming), suggest that adapting the PE intervention for care assistants can better prepare them to deal with their multifaceted role. Yet, PE interventions in the context of formal care have received little attention in the literature. Rather, the majority of research has focused skills training or knowledge based interventions aimed at enhancing care assistants' technical competences (8, 9).

The authors of the current manuscript conducted a controlled pre-posttest study in four aged-care facilities to assess the impact of a PE intervention on care assistants [names deleted for the integrity of the peer review process]. Understanding whether and why an intervention fails or succeeds depends, not only on the measurement of outcomes, but also on identifying those factors that act as either facilitators or barriers to its successful implementation.

The purpose of the present study was to describe care assistants and managers' perceptions about the factors that were relevant to the success or failure of the PE intervention. This is the first study, to the best of our knowledge, to explicitly explore the facilitators and barriers to PE interventions targeted at care assistants in aged-care facilities from two perspectives. This aim is to provide new insights into the factors that would support the potential more widespread application of such approaches in this important setting.

Psycho-educational intervention content and results

The psycho-educational intervention sought to provide care assistants with information concerning person-centred dementia care and strategies to cope with several work-related stresses. A literature review about interventions for care assistants, findings from a pilot-study and pre-test interviews with different grades of staff informed the design of the intervention [names deleted for the integrity of the peer review process].

The intervention consisted of eight ninety minute weekly sessions containing two key components: educative and supportive. Each session followed the same sequence and structure: i) discussion of the prior session's 'homework' assignment; ii) overview of the content of the current session; iii) educative component; iv) supportive component; and v) homework assignment to be completed prior to the next session. The sessions were facilitated by a gerontologist and a physical therapist experienced in leading groups. In the three days following each session, the same professionals assisted each care assistant individually during morning care to reinforce the key learning points. A more detailed description of the intervention can be found in Table 1 and elsewhere [names deleted for the integrity of the peer review process].

Published data show that, compared to the education-only group, the PE intervention was not more effective in reducing care assistants' stress or job dissatisfaction, but findings demonstrated a significant reduction in their levels of burnout. Participants reported that the intervention contributed to improved knowledge about dementia and enhanced their feelings of being worthwhile, as well improving group cohesion, emotional management and self-awareness [names deleted for the integrity of the peer review process]. Also, findings revealed positive short-term effects on care

assistants' communicative behaviours with residents with dementia [names deleted for the integrity of the peer review process].

< Insert Table 1 about here >

Methods

Design

The post-intervention qualitative evaluation was an important part of the overall experimental pretest-posttest design that was conducted in four aged-care facilities. After being matched for staff/resident ratio and proportion of residents with dementia, facilities were randomly assigned to the psycho-educational intervention (experimental) or education-only intervention (control). Detailed information about the design of the original study can be found elsewhere [names deleted for the integrity of the peer review process]. For the purpose of this study, only data from the experimental group were examined.

The main study was approved by an ethics committee [names deleted to maintain the integrity of the review process].

Setting

The two aged-care facilities (non-profit-making facilities of collective accommodation) had a staff/resident ratio between 1:2 and 1:3 and a residents with dementia/total of residents' ratio between 1:3 and 1:5. Organisationally, at the head of each facility was the administrator (the person or company responsible for management and administrative operations). Below was the care-home or middle manager (a qualified professional in social work who supervises the care assistants, oversees residents' care and performs administrative functions). The frontline workers, the vast majority of which are care assistants, are supported by a small number of part-time nurses, doctors, physical or occupational therapists.

Participants

The managers of each facility were informed about the study and asked to identify all care assistants that met the following inclusion criteria: i) provide regular personal care to people with dementia (e.g., bathing, and toileting); and ii) had been employed for at least 2 months. Temporary workers, trainees, care assistants working only on the night shift and other health and social care practitioners (physicians, nurses and social workers) were excluded as the latter in particular have little interaction with the residents. A meeting with eligible care assistants and managers was scheduled to provide detailed information about the study and invite them to participate. Potential participants were informed about the purpose of the study and the voluntary nature of their participation. Anonymity and confidentiality were guaranteed and written informed consent was obtained prior to any data collection.

All eligible care assistants (n=27) in the two experimental facilities were offered the PE intervention. Of these, 25 completed the posttest focus-group interviews and 21 the six-month follow-up interviews. Absence from work was the main reason for dropouts. Also, the two managers were individually interviewed immediately and six months after the intervention.

Care assistants were all female, mostly married (63.0%) and with a mean age of 43.37 years (±10.0). The average length of employment as care assistants was 9.84 years (±4.86). Both managers were female and had a college degree in social work. Their mean age was 45.5 years (± 10.26) and the average length of employment was 11.5 years (±6.36) (Table 2).

< Insert Table 2 about here >

Data collection

Focus-group interviews. A total of seven focus-group interviews were conducted two weeks and six months after the end of the intervention. Each focus-group involved four to eight care assistants and met once for no more than 90 minutes in a quiet room at the facility.

An experienced researcher moderated the groups, which were audio-recorded with the permission of the participants. Questions were formulated using a semi-structured interview guide that was revised by all the authors. Interviews began with an identical introduction, informing participants

that they would be asked their opinions about the intervention and reassuring confidentiality. It was emphasised that there were no right or wrong answers. First, participants were invited to freely describe their opinions about the intervention. Subsequent questions were focused on aspects that may have positive or negative influenced the effectiveness of the intervention (Table 3). Each interview was transcribed *verbatim*.

Individual semi-structured interviews. Semi-structured, 30-45 minute individual interviews were held with the manager of each facility two weeks and six months after the intervention. The interview guide was similar to that used for the focus-group with care assistants, and explored the managers' opinions about the intervention and main factors that may have an influence (positive or negative) on the effectiveness of the intervention (Table 3). The meetings began with the interviewer reviewing the topics to be discussed and assuring the anonymity and confidentiality of data. Questions were then generated and followed by probes and paraphrasing of content to elicit more detail. Each interview was audio-recorded and transcribed.

< Insert Table 3 about here >

Data analysis

Both the individual and the focus-group interviews were subjected to thematic analysis. The process of creating and developing the codes and themes was gradually refined by two independent judges (AB and DF) as follows (10): i) data were transcribed and repeatedly read so that the judges became familiar with it; ii) a list of preliminary codes was created; iii) the codes were sorted into subthemes and then organised into the key-themes; iv) the themes were reviewed and refined to form a coherent pattern; v) clear definitions and names for each (sub) theme were generated; vi) critical feedback was provided by all the other authors. Data were managed using qualitative data analysis software - webQDA (University of Aveiro, Portugal).

Results

Data analysis showed that factors relating to the intervention, the workers, the organisation and residents were perceived as critical to successful implementation. A summary of the facilitators and barriers is provided in Table 4. Facilitators included: i) the intervention format and delivery (duration of the sessions and their timing); ii) provision of emotional support; iii) provision of individual assistance; iv) coordinators' characteristics; and v) care assistants' positive attitudes. Barriers included: i) intervention format and delivery (short-duration); ii) time and human constraints; iii) limited management support; iv) care assistants' negative attitudes; and v) residents' level of disability.

While facilitators and barriers are presented separately, they were in reality inter-linked and were not mutually exclusive. Similarities and differences emerged between care assistants' and managers views. The themes described below are supported using illustrative extracts from the data. All names have been changed to protect participants' anonymity.

Facilitators

Intervention format and delivery. Both care assistants and managers considered that the intervention was useful, interesting and relevant to the care assistants' day to day work, with the content of the sessions being much appreciated. The number and length of the sessions were seen as appropriate as they did not cause the care assistants to suffer *'from fatigue'*. Both interviewees stated that the delivery of the intervention fitted into the routine of the home and that shift change-over was the most appropriate time to deliver the intervention as it '*allowed the participation of a large number of care assistants'*.

Provision of emotional support. Both managers and care assistants valued the supportive component. For managers, the emotional support was the most important part of the intervention. They saw the addition of a supportive component as being essential to improving the care assistants' motivation and feelings of being supported. It allowed and encouraged them to talk about their anxieties and emotional problems and fostered positive relationships between co-workers. The manager below described how this had positively impacted on their attitudes towards work:

> "The fact that they were in a group where they could think, share, vent and talk about themselves and about their problems helped them considerably (…). I think they are more aware of how to manage their own stress. Although tired, they are calmer in relation to work and know how to control their emotions." [Rita, manager]

Additionally, the supportive component raised the managers' awareness of the need to provide a physical space specifically for care assistants where these could meet and talk freely about themselves and their feelings about their work:

> "I think that a small and cosy space for DCWs where they could have dialogue, share and clarify what each other is missing. I believe this is something that could be useful to them and to practice." [Maria, manager]

The care assistants themselves were particularly enthusiastic about the relaxation exercises that were practiced at the end of the supportive component. They reported that all too often the emphasis of any education is placed on the technical aspects of care and the residents' well-being while overlooking their own. The relaxation sessions were seen to counter this, they were rewarding.

> "I appreciated all the supportive sessions. As this was an intervention about dementia I thought it would be only focused on residents (…) but we could (also) relax, which is something that we had never had (before)". [Anna, care assistant]

The realisation of the benefits of relaxation, led the administration of one of the facilities to consider the development of a specific space where workers could relax.

> "They [care assistants] all found the relaxation very rewarding and during those minutes they could relieve and relax. The administration has demonstrated openness and flexibility to create relaxation activities with workers." [Maria, manager]

Provision of individual assistance. The individual assistance given to the care assistants during morning care was highly appreciated by both care assistants and managers and was considered crucial

to establishing changes in practice. It offered time for reflection and feedback and an opportunity to practice and reinforce skills:

> "Our last training was very informative. Having sessions and then several days of practical assistance was essential. Care assistants don't (just) need more knowledge, they need to practice, they need to implement what they learnt". [Maria, manager]

> "It was very important to have the theory coupled with the practice. During individual assistance we were relaxed, we didn't rush things. We tried to work as we have been taught and this has become routine". [Andrea, care assistant]

Coordinators' relationship skills. The coordinators were described as being kind and supportive by participants and this was seen as key to the success of the programme. Care assistants felt that the coordinators were approachable and made themselves available to discuss problems. Hence, the care assistants felt that their feelings were really listened to, rather than being ignored. The *'openness, empathy and understanding'* demonstrated by the coordinators provided an opportunity for sharing, not only with the coordinators but between themselves. Care assistants therefore felt at ease and forged closer connections with their co-workers through *'discussion of their personal experiences'*. Furthermore having 'experts' involved to share their knowledge and experience was appreciated by the care assistants, who reported that this made them feel more confident.

> "The coordinators' work was very important. They valued us, which is something that we need. Despite being experts we never felt distantness, they knew how to interact with us." [Andrea, care assistant]

Care assistants' positive attitudes. Based on their observations both care assistants and managers noted that the care assistants were highly satisfied with and motivated by the PE intervention. One manager noted that the intervention led care assistants to work with enthusiasm.

> "I never have seen them [care assistants] so motivated with an initiative. They were devoted to improve." [Maria, manager]

Barriers

Intervention format and delivery. As already noted some aspects of the format and delivery of the intervention were viewed positively, whereas others were not. Although the duration of the sessions and their timing during the day were viewed positively, both managers and some care assistants reported that the short-duration of the intervention as a whole was a limitation and that additional sessions and more formal follow-up would have been beneficial to help establish any changes in practice. Care assistants in particular stressed the need for more emotional support to improve both their own wellbeing and care practices.

> "The supportive component, especially the relaxation, could be longer. Over time we become exhausted and can no longer deal with the residents' mood changes. That would help us." [Catherine, care assistant]

This suggests that despite the initial enthusiasm for such sessions, and the intention to provide both time and space for them to continue, they lapsed after the formal intervention had concluded. As suggested below, this may have been due to pressures on limited resources, with other activities having to take a priority.

Lack of time and human resources. Two weeks and six months after the implementation of the intervention, heavy workload, resulting in 'time constraints', 'understaffing' and 'multi-responsibilities', were reported by care assistants as the major factor hindering changes to practice being sustained. Participants found it difficult to follow many of the intervention recommendations, for example, taking time to communicate with residents, due to time constraints and the busyness of their shifts:

> "Our problem is lack of time. That's our problem. We should have cleaning staff and care staff (…) so we would be less busy and stressed and we would have more time to interact with the residents". [Anna, care assistant]

At 6 months follow-up, managers also highlighted the problems posed by the lack of time and human resources. As one manager noted care assistants often felt '*frustrated given the impossibility to put everything into practice'.* The demotivating effects of being aware of the potentially beneficial changes to practice that are possible but subsequently not being able to put them into practice is a something that has been well described in the literature, and will be considered further in the discussion. In addition to constraints imposed by lack of resources, care assistants also felt that their managers were not as supportive as they might have been.

Lack of management support and encouragement. Care assistants recognised that their managers were an essential source of ongoing advice and guidance, but considered them to be too far removed from the reality of life and problems *'on the floor'*. Care assistants felt that their skills and commitment were rarely acknowledged and that their work was went largely unappreciated. This was seen to impact negatively on their job performance and morale. This may explain why some of the early benefits of the intervention were not sustained over time.

Some care assistants suggested that the integration of training for managers into the intervention would be a way of creating a more supportive environment that would both recognise their contribution and support them to transfer the skills and knowledge they had into practice. Particular emphasis was placed on the need for interpersonal skills training for managers.

> "We need a manager that could supervise and be an effective leader (…) our efforts need to be recognised (…) when we feel confident we provide better care than when we have our confidence damaged". [Claire, care assistant]

> "It would be important if they [managers] knew how to communicate with us…they are…. destructive. Instead of saying 'that's wrong!' they could rather say 'you can do better the next time!'". [Rose, care assistant]

Interestingly, at six months follow-up the managers perceived themselves as pivotal to achieving and sustaining practice change, but, as with the care assistants, they found themselves too

'busy attending to the daily demands of keeping the organization going' and having *'no time'* to support care assistants. This suggests a 'firefighting' approach in which what limited time there is, is devoted to the essential tasks necessary to keep basic organisational functions operating.

Therefore, although the managers were aware of the purpose of the intervention and recognised the need to be more involved so that they could better support care assistants, this proved impossible in practice:

> "It is important that we could be more involved or that meetings could be scheduled so we might understand how they are working and how to support them." [Rita, manager]

Care assistants' negative attitudes. Paradoxically, while the care assistants described a lack of managerial support as a barrier to achieving lasting change, care assistants' own resistance to change was the only barrier reported by managers immediately after the intervention. One manager argued that as many care assistants had been in their role for considerable periods of time they had become rigid and developed a closed-mind, which made them highly resistant to change and less willingly and able to adjust to new situations. Managers also stressed that a number of the care workers were (or had become) 'indifferent' to their work and that those who did wanted to improve their practice were often discouraged by their more resistant colleagues. The inclusion of periodic follow-ups to the intervention was mentioned as a way to provide ongoing support for care assistants, to keep them motivated to change:

> "I feel that, for a while, they did things well, but they eventually returned to their previous behaviours... that's where I think there must be more effort…maybe through regular workshops to revive their knowledge." [Maria, manager]

For one manager, training care assistants' about dementia-related occupational activities would be a facilitator to change. This would allow care assistants to escape from the routine and to feel empowered:

> "My suggestion is the inclusion of an additional component ... it would be interesting that care assistants could develop some occupational activities with people with dementia during their free-time". [Rita, manager]

Residents' level of disability. Given the high levels of physical and cognitive disability amongst the residents with dementia, managers thought that it was difficult to see how the intervention had directly benefited them, something that, combined with the limitations of time and resources, they believed could demotivate the care assistants:

> "We know they [residents with dementia] need more of our time, but they are all so dependent that interaction becomes impossible …having one worker per resident was the ideal." [Rose, care assistant]

<Insert Table 4 about here>

Discussion

The present study sought to obtain the perspectives of both care assistants and managers about the facilitators and barriers to the success of a PE intervention for care assistants working with people with dementia in aged-care facilities.

Findings suggested that several factors inhibit or facilitate the impact and sustainability of the intervention, including the: nature of the intervention itself; the organisational context; care assistants' and managers' attitudes and behaviours; and residents' level of disability. Moreover, findings pointed to both important similarities and differences between managers and care assistants' perceptions.

The majority of the interviewees appreciated the content and duration of the intervention. However, some participants felt that ongoing training and regular updates would have been beneficial in promoting lasting change. This is consistent with previous research which, using a pharmacological metaphor, has suggested that the effects of an intervention are contingent upon the dose received: the larger and more sustained the dose delivered the larger the effects (11). However, it is not only the intervention itself that is important but the opportunities for participants to be encouraged and enabled

to apply what they have learned in their day-to-day work with on-going support and reinforcement (12).

Both managers and care assistants stressed the pivotal role of the supportive component in improving motivation and feelings of being supported. This is a key finding that highlights the importance of care assistants being provided not only with technical competences, but also with emotional support that both recognise and provide them with the means to address their own needs.

A long trajectory (an average length of employment of almost ten years) in a highly physical and emotional demanding job, with heavy workloads and poor working conditions, might predict care assistants' burnout and explain why the supportive component has been largely appreciated. As already noted, the role of care assistants is essential in providing care for people with dementia, although the well-being of these workers remains poorly understood and addressed (13). Supporting care assistants to recognise and address stressful situations may well be critical to sustaining practice change and performance improvement (14). Valuing people with dementia but also those who care for them is a key-element of relationship-centred care (15). Relationship-centred care, as captured by the Senses Framework, highlights the importance of the interdependent relationships necessary to create and sustain an enriched environment of care in which the needs of both residents and workers are acknowledged and addressed (15). This approach has been widely adopted in the UK in initiatives such as '*My* Home Life' (16) which seek to ensure that care homes are positive places to live, work and to visit. This could provide a potentially useful model to frame future interventions within a care home context so that they recognise and seek to address the needs of multiple groups.

Another key element of the current intervention was providing individualised assistance to participants during morning care. This is consistent with previous studies that have pointed out that opportunities to practice and reinforce skills are essential to sustaining practice change, as this helps to integrate the new knowledge into existing routines and allows participants to explore how to change the way they work most effectively (12, 17).

Immediately after the intervention, care assistants identified the importance of the organisational context to achieving change. This was characterised by a lack of time and human resources and a limited management support, which served as major factors inhibiting change.

Conversely, managers focused on the care assistants' resistance to change as the main barrier to success. Only at 6 month follow-up, managers had recognised the importance of organisational context to achieving change. Overall, these findings highlight the importance of collecting the perception of different grades of staff and conducting follow-up assessments in order to obtain depth information that might be fundamental to plan effective interventions. Additionally, the findings underscore the importance of good channels of communication between managers and care assistants and leadership from the former group, as care assistants perceived that management was distanced from the realities of practice and neither understood nor appreciated their everyday efforts. Rather, given the staffing constraints, management clearly expected care assistants to work "beyond contract".

There has been a great deal written about the importance of leadership in achieving and maintaining change in care settings (See Patterson *et al.* 2011 for a review). All too often, managers focus on the administrative components of their role as opposed to developing their leadership skills. As a result they often lack a full understanding of how to implement and support successful change, fail to motivate others to change and do not reward or recognize individuals who make an effort to change the way things are done (18-20). This suggests the need for the sort of culture change promoted by initiatives such as '*My* Home Life' (16) in the United Kingdom or in the United States of America via 'PioneerNetwork' (21). Both encourage person or relationship-centred care through reorientation of the facility's culture - its values, attitudes, and norms - along with its supporting infrastructure, such as breaking down hierarchies, building organisational commitment and giving care assistants more control over work environment (22).

However, improving the care of people with dementia and valuing those who provide this care also requires culture change at professional and societal levels. It is entirely unreasonable to expect care homes, and the people who work in them, to change their culture if the importance of work in such environments is not fully recognised, supported and rewarded. Interventions such as PE will not be optimally effective until such far reaching changes occur.

We would argue that the present study has provided important insights into the potential value of PE interventions designed to support care assistants working with people with dementia, and how

these might be developed in the future. However, it is important not to make sweeping claims and to recognise the limitations of the present study. Given that the first author was involved in all aspects of both delivering the intervention and data collection the influence of a *halo effect* (i.e. the impact of the researcher's personal biases and idiosyncrasies) must be considered. Moreover, although efforts were made to ensure that all the participants were fully involved in the focus-groups interview, it is possible that group-conformity i.e. a tendency for participants to conform with the opinions of the most outspoken elements, existed. Finally, the insights produced cannot be generalized to other people or settings. Nevertheless, they are consistent with several other studies that have explored the impact of training or educational initiatives in care homes (11, 23). The findings further reinforce the importance of seeing these initiatives as an important stimulus for change, but one that must be embedded within a more comprehensive, multifaceted and ongoing effort that focuses on the needs of all groups who live, work and visit such settings.

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Table 1. Content of the psycho-educational intervention [names deleted for the integrity of the peer review process]

Session	Component	Content of the psycho-educational intervention
1	Educative	*Information about PCC and dementia:* Information about the concept and principles of PCC. Basic information on dementia, its causes, symptoms and evolution.
	Supportive	*Emotional impact of care:* The positive and negative impacts of the care experience on personal and professional life; Abdominal breathing.
2	Educative	*Communication in dementia:* Verbal and non-verbal communicative strategies to interact with residents with dementia (e.g. give simple choices; use validation; allows time to respond; use individual's name and eye contact).
	Supportive	*Conflict management:* Improving assertiveness through the DESC technique (Describe; Explain; Specify; Conclude) technique (Bower & Bower, 2004). Stretching and strengthening exercises.
3	Educative	*Challenging behaviours:* Information about challenging behaviours and strategies to deal with them.
	Supportive	*Teamwork:* The importance, benefits and constraints to teamwork; strategies to enhance cooperation between DCWs (e.g. active listen, positive feedback). Cognitive relaxation technique.
4	Educative	*The environment and dementia*: Strategies to enhance the physical and social environment for the person with dementia (e.g. decrease background noise; post signs as reminders); information about the risk factors and strategies to prevent falls.
	Supportive	*Deal with emotions:* Improving emotion-management strategies through the activity "six colours to think" (based on Bono, 1985); Stretching and strengthening exercises.
5	Educative	*Motor stimulation:* Information about motor stimulation; strategies to enhance residents' involvement in daily care (e.g., break the small steps of an activity); and techniques for the moving and handling of residents.
	Supportive	*Time management:* The impact of poor time management on personal and professional life and tools for better time management (e.g. set priorities; use a planning tool). Mental body-scan.
6	Educative	*Multisensory stimulation - olfaction:* Information about multisensory stimulation; dementia-related olfactory changes and strategies to stimulate the olfaction during the daily care (e.g., use shower gel of different fragrances; place aroma diffusers in the bedroom)
	Supportive	*Problem-solving:* Using the problem-solving technique: (a) identify the problem; (b) explain the problem; (c) create solutions; (d) choose one solution; (e) plan the implementation of the solution; (f) evaluate the efficacy. Stretching and strengthening exercises
7	Educative	*Multi-sensory stimulation – vision and tactile stimulation:* The importance of vision and touch for people with dementia, dementia-related visual and tactile changes; strategies to stimulate the vision (e.g. reality orientation) and touch (e.g. hand massage during bath)
	Supportive	*Relaxation*: Yoga
8	Educative	*Multi-sensory stimulation – audition and taste:* The importance of audition and taste for people with dementia; dementia-related audition and taste changes; strategies to stimulate the audition (e.g., listen to residents' favourite song) and taste (e.g. brush the person's teeth with toothpastes of different flavours). *Celebration and finalization* - Participants reflected on the balance of their participation in the group. Photographs of the whole group were taken and a snack was prepared.

Table 2. Participants' sociodemographic characteristics

Outcome	N (%)
Direct care workers (n=27)	
Gender	
Female	27 (100.0)
Age in years	
M (SD)	43.37 (10.00)
Marital Status	
Married	17 (63.0)
Widowed	1 (3.7)
Single	2 (7.4)
Divorced/separated	5 (15.5)
Other	2 (7.4)
Education	
Primary school	4 (14.8)
Middle school	6 (22.2)
High school	11 (40.7)
College degree	1 (3.7)
Other	5 (18.5)
Average length of employment	
M (SD)	9.84 (4.86)
Managers (n=2)	
Gender	
Female	2 (100.0)
Age in years	
M (SD)	45.50 (10.26)
Marital Status	
Married	2 (100.0)
Education	
College degree	2 (100.0)
Average length of employment	
M (SD)	11.5 (6.36)

Abbreviations: M, mean; SD, standard deviation

Table 3. Interview guide

What general considerations do you want to make about the intervention?
What did you like most and least about the intervention?
What factors hindered the implementation of the intervention?
What kind of readjustments in its contents and structure do you suggest?

Table 4. Facilitators and barriers to the implementation of the intervention

	Post-test		6 month follow-up	
Factors	Care assistants	Managers	Care assistants	Managers
(1) Related to the intervention				
Intervention format and delivery	+/-	+/-	-	-
Provision of emotional support	+	+		
Provision of individual assistance	+	+		
Coordinators' characteristics	+			
(2) Related to the organisation				
Time and human resources	-		-	-
Management support	-		-	-
(3) Care assistants' attitudes	-/+	-/+	-	-
(4) Residents' level of disability				-

Notes:

+ Facilitators, -Barriers